STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157590	A. BUILDING _____ B. WING _____	09/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEM CITY HOME CARE	2346 S LYNHURST AVE STE 301 INDIANAPOLIS, IN 46241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This visit was a Home Health federal recertification survey. This was a partial extended survey. Survey Dates: September 3-6, 2013 Partial Extended Survey Dates: September 5 - 6, 2013 Facility Number: 011342 Provider Number: 157590 Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor Census Service Type: Skilled: 208 Home Health Aide Only: 0 Personal Care Only: 0 Total: 208 Sample: RR w/HV: 5 RR w/o HV: 8 Total: 13 Quality Review: Joyce Elder, MSN, BSN, RN September 17, 2013 This survey was modified as the result of an IDR 9/27/13. je	G 000		
G 110	484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to	G 110		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 110	Continued From page 1 maintaining written policies and procedures regarding advance directives. The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. This STANDARD is not met as evidenced by: Based on admission packet review, observation, and interview, the agency failed to ensure patients were provided the Indiana advance directives, including a description of applicable State law, in 5 of 5 patient admission packets reviewed during home visits with the potential to affect all patients at this agency. (#1, #2, #3, #4, #5) Findings include: 1. The agency's admission packet failed to evidence the Indiana Advanced Directives effective May 2004 document. 2. The home folder for patient #1, start of care 8/23/13, failed to contain the Indiana Advanced Directives effective May 2004 document within the admission packet during the home visit on 9/3/13 at 3:05 PM. 3. The home folder for patient #2, start of care 8/30/13, failed to contain the Indiana Advanced Directives effective May 2004 document within	G 110		

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G 110	Continued From page 2 the admission packet during the home visit on 9/4/13 at 9 AM. 4. The home folder for patient #3, start of care 8/14/13, failed to contain the Indiana Advanced Directives effective May 2004 document within the admission packet during the home visit on 9/4/13 at 10:30 AM. 5. The home folder for patient #4, start of care 8/30/13, failed to contain the Indiana Advanced Directives effective May 2004 document within the admission packet during the home visit on 9/4/13 at 1 PM. 6. The home folder for patient #5, start of care 7/26/13, failed to contain the Indiana Advanced Directives effective May 2004 document within the admission packet during the home visit on 9/4/13 at 3 PM. 7. On 9/3/13 at 2:15 PM, employee X, Administrator, indicated the Advanced Directives were not solely for Indiana but was aware that the Indiana Advanced Directives effective May 2004 document needed to be in every admission packet.	G 110		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and	G 159		

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G 159	Continued From page 3 any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure all medications were included on the plan of care in 1 of 13 clinical records reviewed with the potential to affect all patients at this agency. (#7) Findings include: 1. Clinical record #7, start of care (SOC) 3/22/13, evidenced a document titled "Medication Profile - Supplemental" that indicated Amoxicillin was added to the medication profile on 4/10/13. The plan of care failed to evidence an order for Amoxicillin. 3. On 9/6/13 at 1:56 PM, employee X, Administrator, indicated a MD signed Amoxicillin order needed to be within the patient's record and the medication needed to be on the plan of car.	G 159		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.	G 236		

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G 236	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure all entries were clear and correct in 1 of 13 records reviewed with the potential to affect all patients receiving services (#10). The findings include: 1. Clinical record #10, Start of Care 7/26/13, included a document titled "Telephone Order" with an order date of 9/5/13 for Tylenol Arthritis 650 mg every night by mouth and Pravastatin Sodium 10 mg by mouth every night effective 8/15/13. The document failed to show the ordered date as 8/15/13. 2. During an interview on 9/5/13 at 5:31 PM, employee X, Administrator, indicated the order date should have been 8/15/13 and not on 9/5/13.	G 236		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the medication profile was updated and accurate when there were medication changes in 2 of 13 clinical records reviewed with the potential to affect all patients at this agency. (#7 and #8)	G 337		

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G 337	Continued From page 5 Findings include: 1. Clinical record #7, start of care (SOC) 3/22/13, included a document titled "Medication Profile - Supplemental" that indicated that Hydralazine was added to the medication profile on 4/8/13 and Amoxicillin was added on 4/10/13. The medication profile failed to evidence a RN signature that these medications had been reviewed. 2. Clinical record #8, start of care (SOC) 8/5/13, included a document titled "Medication Profile - Supplemental" that indicated that Hydrocodone-Acetaminophen was added to the medication profile on 8/14/13. The medication profile failed to evidence a RN signature that this medication had been reviewed. 3. On 9/6/13 at 1:59 PM, employee X, Administrator, acknowledged the RN needed to sign and review the medication profile each time a new medication was added.	G 337		